

OUR LADY OF THE ANGELS
EMERGENCY MEDICAL AUTHORIZATION
(Faculty, staff, volunteers)

(please print)

NAME _____ BIRTH DATE _____
SOCIAL SECURITY # _____
ADDRESS _____ PHONE _____
WHERE EMPLOYED _____ PHONE _____

IN CASE OF AN EMERGENCY, PLEASE CALL

FIRST CONTACT'S NAME _____ RELATIONSHIP _____
WORK PHONE _____ HOME PHONE _____

SECOND CONTACT'S NAME _____ RELATIONSHIP _____
WORK PHONE _____ HOME PHONE _____

THIRD CONTACT'S NAME _____ RELATIONSHIP _____
WORK PHONE _____ HOME PHONE _____

In case of accident or serious illness, I request the school to contact my designate. If this cannot be done, I authorize the school to call the physician or dentist listed on this card and to follow his/her instructions. If the physician or dentist named cannot be reached, the school may seek medical services that seem necessary. I realize the school does not assume responsibility for the payment of medical expenses.

SIGNATURE _____ DATE _____

In the event emergency treatment is needed, I give the hospital, its authorized personnel and/or doctor permission to treat me as necessary.

SIGNED _____ DATE _____

ALLERGIES _____

MEDICAL PROBLEMS _____

TAKING MEDICATIONS: YES _____ NO _____

If yes: TYPE _____ DOSAGE _____ REASON _____

PHYSICIANS/CLINIC _____ PHONE _____

DENTIST _____ PHONE _____ HOSPITAL _____

OR

I do not give my consent for emergency medical treatment. In the event of illness or injury requiring medical treatment, I wish the school authorities to take no action or to: _____

SIGNATURE _____ DATE _____